State of Connecticut
Health Enhancement Program
CO-1320 NEW 10/2012

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

APPLICATION FOR REINSTATEMENT OF FINANCIAL INCENTIVES HEP ACTIVE STATUS

Important Information

This form must be used by employees who are ineligible for financial incentives under the Health Enhancement Program (HEP) because they or an enrolled dependent were deemed non-compliant with one or more HEP requirements. Use this form to document compliance with outstanding requirements and seek reinstatement in HEP active status. Your physician must complete this form to record completion of a requirement or to indicate that he or she is providing an explanation why it is clinically inadvisable for an individual to complete a HEP-required screening. **The physician must complete and sign this form.** A separate form must be submitted for each non-compliant member. It is the employee's responsibility to submit this form to the Healthcare Analysis Unit of the Office of the State Comptroller after you and your enrolled dependent have fulfilled outstanding and reported HEP requirements. If an exemption is claimed the physician must also provide a written explanation by submitting a Physician Notification Form (CO-1317NCR) to the member's medical carrier **(See below**).

Member Information (Required and must match exactly to what is listed on your Medical/Dental Plan ID card.)

Member Identification Number	Group Number	Employee ID	Dept ID

Employee/Retiree: Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
			/ /

Non-Compliant Person: Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
			/ /

Home Address – Number and Street Name	City	State	Zip Code

Telephone	Email Address
( ) -	

Member Signature	Date
X	/ /

Submit Completed Applications To: Healthcare Analysis Unit, Office of the State Comptroller, 55 Elm Street, Hartford, CT 06106 or fax to (860) 702-3556.

INSTRUCTIONS FOR PHYSICIANS/PROVIDERS: Please use this form to report this member's completion of a required health screening/service. To do so, check the appropriate screening/service, complete the date of service, place your initials next to the corresponding item, and sign the bottom.

If it is determined that a required screening is not medically advisable for the member noted below, you must also submit a Physician Notification Form (CO-1317NCR) to the member's medical carrier.

Non Compliant Person: Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
			/ /

(Physician Use Only)

Check Applicable Box on Left for Each Item Being Reported		Completed (MM/DD/YY)	Exempt		Provider Initials
☐	**Preventive Well Visit Exam** (Including vision exam screening)	/ /	☐	Member is exempt from completion due to a medical condition or other health factors. A completed Physician Notification form has been submitted to the member's medical carrier.	
☐	**Cholesterol Screenings** Once every: 5 years (ages 20-29), 3 years (ages 30-39), 2 years (ages 40-49) and every year (ages 50+)	/ /	☐	Member is exempt from completion due to a medical condition or other health factors. A completed Physician Notification form has been submitted to the member's medical carrier.	
☐	**Dental Cleaning(s)** (If enrolled in a State of CT plan)	/ /	☐	Member is exempt from completion due to a medical condition or other health factors. A completed Physician Notification form has been submitted to the member's medical carrier.	

Provider Information (Required)

Provider Name / Name of Clinic	Provider ID # (If Applicable)	Telephone	Fax
		( ) -	( ) -

Office Address – Number and Street Name	City	State	Zip Code

Provider Signature	Tax ID #	Date
X		/ /

THIS SECTION TO BE COMPLETED BY AUTHORIZED PERSONNEL

OSC Received: / /	Reinstated Payroll Check Date: / /
Approved for Reinstatement ☐ YES ☐ NO	If No, reason:

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